

UNC Chapel Hill CEDI Lecture Series: Jessica Schomberg

Thursday, January 17, 2019

Frameworks for Discussing, Researching, Experiencing & Living Disability

Transcript (Closed Captioning provided by Alternative Communication Services)

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>> Okay, I'll get myself on the screen.

Yes, thank you for joining us for our first guest lecture. This guest lecture is part of both the CEDI lecture series and our course in disability informatics and information.

Thank you for joining us. And online, thanks.

Thank you to Jessica, who was so kind in being our first guest lecturer. I'll do a brief bio introduction for Jessica and hand over the reigns.

There is closed captioning available. If you can't access that, let me know and I'll see what I can do.

Jessica became interested in cataloging in high school.

After arguing where the library cataloger fiction should be shelved.

And she's in the chair at the Montana state university.

Their educational background includes MA in English, teaching English as a second language, and an MLIS from U Washington in Seattle.

For their disability related writing. We have a list on the website. And I'll let Jessica take it away.

(Minnesota state university).

And hand over...

>> Hello.

>> We can hear you, can you hear us?

I'm muting us now.

>> I can hear you. First of all, I want to thank Dr. Gibson for inviting me.

And this is a great opportunity. And this class looks amazing and I might have to read with your class over the semester. This is exciting to see this in progress.

I'll be presenting a frameworks about how people think and theorize about disability and how that is progressed over time. And western Europe and the United States.

Please note I have only lived in the United States. I have not lived in another country with a different model how to approach disability. So there's a lot I'm going to leave out because of my own ignorance.

Learned a lot from different people over the years. And I won't have a thank you list for them. Because honestly I think half of them are not public about their disability status because they are afraid of retaliation at their workplace. And I can't remember who is open and who is not.

I'll say there are a lot of people I could thank at the end of this, but I can't because it's not safe to do so. Which to me is a big loss in our community that people can't safely express something as simple as their disability status.

Moving on from that, I'll share a slide show with you. I posted this online. And I also tried to provide a couple different options for how to view this and how to read along. I did provide notes. I didn't know there was going to be a captioner with this presentation. So I wanted to make sure people could go back and get something if I spoke too fast or if sometimes we just don't catch everything verbally. And I wanted to make sure the notes would be available.

I think my Twitter address is listed. And that's easy to find my work email address.

If you have questions after this, send me a message, and I'll happily talk with you about whatever you want to talk about. But I'll get to the slide show now.

And we will just...start. So on the second slide after the title slide, disability is an area of study for a lot of people. But it's also the reality for a lot of people and you might not know that. I guarantee if you ever had a job, you worked with people who have

disabilities, you may or may not have noticed or ever been told. They may not have felt safe to share or identified as a person with disabilities even if they were covered by governmental standards.

Most of my research is in terms of disability in the workplace. That's mostly what I'll be talking about. Things to think about in terms of disability in the workplace. I assume some of you attended professional conferences. Some haven't. If you haven't, think about your attractions with education going to school, getting services you need there.

So think about was transportation easy to arrange? Was it easy for you to move around that conference? Was water freely available? I think is that Charlottesville, where UVA there, and there's a tiny airport that doesn't have a water fountain. And I was there after another conference and trying to leave the city. The conference itself was great but the airport in that town was really challenging to me as a person with multiple medical issues that cause me to get dehydrated really fast.

As we think about setting up conferences, is it a physically welcoming environment from the indictment time they enter the community.

Are the foods inclusive of dietary needs? Did they have bathrooms accessible to all attendees. Was there a place for people to take a break or administer medication. I have diabetes, and I wear medical equipment as part of that. Sometimes it has issues I'm not prepared for and the environment I'm in is not prepared for. And I would like to change out medical supplies and I can't because there's no sterile place for me to do that, which makes me not want to go places because I don't know what to expect.

As you think about conferences or educational sites, do all the chairs fit all the bodies?

Were there options for people who couldn't be present? Did every speaker at the conference use a microphone? I've been in small conference settings, where there are rooms with really thin partitions from one to the other. And I don't have diagnosed disabilities related to my hearing, but I also sometimes can't hear people well if there's another big thing in the room next door. And people think it's small enough, we don't need a microphone. But some people in the audience do benefit from having them.

Were transcripts of presentations provided during or after the presentation? Did the presenters use a font large enough in the slide or use a slide with all text? Did attendees ask invasive questions about someone's use of a cane to get around or make remarks about a scooter to get around?

This is a long list of questions, based on my negative experiences at conferences or the negative experience of friends of mine. These are common issues that people experience as they try to participate in professional opportunities. So when we're talking about disability, it effects people that

you know assuming multiple people in the audience with disabilities. So you know this. But some people, it's new.

There are a lot of reasons people don't necessarily identify themselves as having been a disability. Or as being disabled. I think of disabled as a political identity. And it took me a long time to get comfortable with that because I felt I was taking away from someone else by taking on that identity. But the reality is I'm protected by the Americans with Disability Act. I have multiple disabilities. The term disability as a political identity, me taking it on, made me feel safe and comfortable in my vocation in a specific way that benefited me.

And I feel my growing comfort with that label makes me feel more empowered to engage in activities like this. So that's my personal journey to accepting this label. Some people will accept it. Some people won't. And there's all sorts of different reasons for why or why not.

Those who are less likely to think of themselves as disabled have jobs, higher levels of education and higher incomes. The people you meet at a university are probably less likely to identify as disabled than people who don't have jobs, don't have qualifications to get

jobs, and don't have income. There's a lot of -- I'll skip that.

Also, one interesting thing is that people whose impairments began at birth are more likely to identify as being disabled than those who acquire impairments during the aging process. Part of that is what you are comfortable identifying with. And if you find a utility at an early age in accepting this identity, you are more likely to hold it with pride.

One interesting thing is that in the world, who estimating depression will be the leading cause of disability by 2020? A lot of disability iconography involves people in wheelchairs or people who use a cane. But if most people with a disability have what is called an invisible disability, it's something to think about about, who does -- who is represented by the symbols we use? Who do we envision in our heads when we think about people with disabilities?

Invisible disabilities include chronic joint pain, which might have cycles of flare-ups, which means one day someone uses a cane and one day they don't. You can't tell from the outside what they are experiencing. Maybe they had this condition since birth. Maybe it's recent. Maybe they can't get a diagnosis because their workplace won't give them the freedom to go to specialists or their workplace doesn't pay enough to see a specialist to get that diagnosis.

If people saying I'm using -- if you see someone use a cane one day and not another day, trust they know what they are experiencing and what they need. Also, if you are supervising someone or working with someone, maybe one day they use a cane and can't do a lot of shifting in the stacks. Well, if they say that, don't make them go shift in the stacks. Find them something else to do.

And don't talk negatively about them. I heard too many stories like that. And I don't know if people who haven't heard those things know those stories. Other types of invisible disabilities include ADHD, epilepsy, kronos, lupus, food allergies, PTSD, it's basically an iceberg. You don't see most of it, but there's a lot there.

Anyway. I just heard a lot of bad things that people with disabilities in libraries have experienced. And it doesn't get talked about because most people who experience it aren't safe to talk about it. I am fortunate enough to have tenure in a library where we have union protections.

I feel of all the people out there who might be able to talk about their experiences, I have probably have more protections than most. To me, this is both a privilege and a responsibility to come and talk about things like that. Because I have too many friends who just are not in a position that I am in.

Anyway, that's a little maudlin. Sorry, we'll move on. Who am I? I know some people who are attending this. But I don't know most, probably.

I have diabetes, the article talks about being a disabled cyborg. And that's my experience. I had diabetes most of my life. And for most of that time, I used insulin injections. Since switching to using a insulin pump, my experience with having diabetes

in the public is that it's no longer invisible. If people see my pump and know what it is, they know right away what is going on with me. What my disability status is. At least in that sense. So when we talk about invisible disabilities, it's not always very cut and dried with that.

I'm also multiple thyroid disorders. Sad, other spooony things. For the most part, that affects my mode and energy level. And those are my experiences. There's other things about me that are unrelated to my disability status. But having disabilities really has impacted how I view the profession and other things around the world.

So when we talk about disability frameworks, this really impacts my view of these frameworks. But these are just my experiences. So...one of the reasons I started putting together the disability bibliography is because there are other experiences I don't have.

And I think it's important we have as many as voices as possible talking about what life is like.

Also, just as a heads up. I'm co-writing a book about library work and disabilities tentatively titled beyond accommodations that's hopefully coming out the end of the year. Much of what I'll be presenting next is from the draft of chapter 1.

If you have questions or ideas and suggestions for how to make it a really good chapter 1, I'll be incorporating those into my rewrites. If you share personal stories with me, I will not incorporate those because I feel like there's an ethical boundary there between using ideas I learn as a think about things and taking other people's stories without permission.

So we will move on to models. You can call them frameworks, models, theories, they are ways of organizing your thoughts around what disability means. Disability as an umbrella term was not used in preindustrial western societies. And also is not currently a concept that exists in every culture. Historically, the focus was often on specific impairments, such as blindness or amputation.

In terms of diabetes, which is my experience, I think a lot of people heard about there's type 1 diabetes and Type 2 and you might not know which is which is that's fine. But the reason we have the concept of type 1 versus Type 2 is finally about 100 years ago, insulin was developed and people with Type 1 lived long enough to develop theories. Now there's 34 different types of diabetes I can name (46 (4 different types)).

And 100 years, people didn't live long enough to have these different theories. Generally speaking, and I'm using the social model for this, did you generally speaking, disablement occurs when there's a gap between environment and the personal came a times. And labeling someone as disabled is used against people in various ways.

White people use the concept to justify the enslavement of Africans. There's an attempt to escape from slavery called [inaudible] and this was a diagnosis of people who are enslaved

are trying to escape slavery. Obviously they must be mentally ill. Because why would anyone want to escape? The diagnosis was leveled against people who attempted escape or fantasized about it. But this diagnosis didn't protect people who attempted to escape from being punished or killed.

And the diagnosis was a way to path jiz people. And it was also used against women who are viewed as promise schoolhouse or had many children and had sterilization. This is not ancient history. This is recent history. This is still occurring in Canada for indigenous women. And there is a link to an article specifically about that from like a year or two ago in my notes if anybody wants to read it. Accusations of disability are used to justify xeno phobic immigration policies, which were often racist and classist.

As I conceptualize disability as a political identity I'm proud of. There's a lot of reasons people might not want to take this label on based on historical reasons. And frankly I can't blame them. So the models also the models that are presented on this slide are presented in the order they were developed. But please remember older models are still in use. And newer models aren't necessarily better or symbolic of progress. They are just tools.

And they might have better uses in some areas than others. I will admitted, I have my own preferences. And you will probably pick up on those easily during this presentation. But they all exist for a reason. And they all sort of are built over a historical time.

So the first model we'll talk about is the moral model. So I am just going to assume you don't need me to read the slide. And I am not going to. But I'll mention what is on there.

The moral model, one word that xemly if Is the model is the word handicapped, which was really the connotations of handicapped are tied to begging, not being a full member of society. being subhuman in some way. I will say that some disabled people do use the word handicapped to describe themselves. They have their own reasons for that. Don't tell someone who uses that word to tribe themselves that's wrong. But in general, this is a word to at this point avoid. There's a lot of other options, instead of saying if you are talking about bathrooms instead of saying handicap stall, you can say wheelchair stall. That's what you mean, people with wheelchairs can get in there. That's important information. The handicapped part is less important.

Instead of saying handicapped parking, say accessible parking or accessible van parking if someone needs a lift in a parking spot that will accommodate a lift.

So in terms of diabetes, which is going to be what I go back to a lot in this. If you ever hear someone make a comment about someone deserving to get Type 2 diabetes because they didn't take care of themselves or eat right or this reason or that reason, they are operating under a moral model. They are making a moral judgment on another person based on their disability status.

So there we go. In case it's not clear, this is not my favorite model. And in fact, it usually makes me mad. If you -- if this is the model you were brought up with, um, that's what your reality is. But I encourage you to think about other options beyond this one.

The next model we'll talk about is the medical model. This is the model I spent my most of my life viewing myself using this model. The defining term for me the medical model is compliance. I get orders from a doctor. I must comply with those orders or I'm a bad patient. And we go back to the medical model of being a bad patient and being undeserving. The medical model and moral model in my mind go back and forth a lot depending on what is happening.

The medical model did not help me to identify as a person with disabilities with pride. It was all about trying to cope. I will say I take part in a lot of online chats with other diabetics. And there's entire discussions about the term compliance is dehumanizing. Compliance is a term used to control people seen as lesser in some way. It's not a way to address adults you respect.

So if you are a with a health care background, you probably been trained to use this in talking with patients. Medical background, you are using the medical model, that's really common. But I encourage you to recognize a lot of your patients will feel disempowered by this model.

Oh, also, just as a note. I talk about having diabetes and being diabetic pretty much interchangeably, but some people strongly prefer to refer to themselves as a person with diabetes. When talking about people with various conditions, it's important to check in with them to see how they self-describe.

So I would like to say thank you to Nell to help me identify I was operating under the medical model because I realized there were other options. He wrote a blog post about that. So I feel okay giving public thanks to him.

We'll move to the rehacks rerehabilitation model. Some people skill this. I'm not sure why. There's a whole academic program called rehabilitation, and they write stuff. And I'm not sure why this gets skipped. With you the defining term of this model is recovery. And it views disability as a problem. You can learn to cope or overcome your disability using various strategies or aids.

Some people, this is the thing that leads people to think because I'm on a insulin pump, I have quote unquote been cured of diabetes when it's just another tool to deliver insulin. I've also in terms of this model, I heard fantasies of a cure for diabetes for most of my life, starting in the mid to early 80s. Starting in the mid-80s, the cure has always been 5 years away. And it's been more than 5 years since the mid-80s. And none of the proposals I have seen at any recent time is anything that would help me.

I am going to say, I'm 99% sure I will never be cured of diabetes. So a lot of times, it feels like a rehabilitation model shouldn't impact me much. But this is what insurance company operate on. The insurance company model is often based on the rehabilitation model. Their tables and their surveillance systems, slash behavioral systems are all designed with this model in mind. It's designed to make life easier for everyone but the disabled person. Instead of fixing the doorway, we'll give people with disabilities different chairs. Maybe people like their chairs or can't afford a new chair. Maybe we should fix the doorways. So that's that.



Moving on to the social model. The social model is what you will often encounter in disability training programs. It often insists on person-first language. And person-first language is totally fine. A person with disabilities. Person a diabetes. Person with autism. The problem with this insistence on person-first language is it disrespects the people who self-identify as disabled, as autistic, as diabetic. If you are in a training program and that person insists the first person-first is the only option to use. Think about this moment and think of a time a person called you a name that is not the name you go by or a name you find respectful.

Maybe we can find the terms people use to self-identify instead of insist using on one option for everything. Once again, like the rehabilitation model, this seems like it's designed to make life easier for everyone but the person with disabilities.

This model is in the activists who operated under this model is one of the main reasons we have the American with disabilities act. And I will say I when I was struggling with how to identify? Do I identify with a person with disabilities? A disable person? Am I a person with diabetes and this doesn't apply to me. I thought about the ADA. And when I was a kid -- well, when I was a kid, thinking I would be covered by the ADA when I wanted to work.

I felt so much safer at that time. To me, that feeling of safety by being explicitly covered by having my disabilities covered by a act of legislation, to me, that sense of safety is a sign that yeah, I have disabilities, yeah, I am disabled. Yeah, having legislation to protect my rights is empowering.

And when I discovered the social model as a concept, that was the first time I felt empowered as a person with disabilities. I felt empowered not as a patient but as a person. But as with any other model. There's a drawbacks. Legislation to regulate the price of insulin won't fix my pancreas. I'll have diabetes and still need regular medical care. While this model strongly resonates with me, it's often used in a way that ignores the medical aspect of my disability. there are barriers but also my pancreas doesn't work and it won't magically start. So that's just my experience. In terms of -- so I have a love-hate relationship with this one.

But thinking of things in terms of if someone has a broken arm. Your arm is impaired and that's a temporary disability. But if your broken arm prevents you from entering the library -- sorry. You have a broken arm, which is an impairment. When you have that situation, and you can't enter a library, the fault isn't with your broken arm, the fault is with doors that don't allow you entrance. That's the key part of the social model I think is really helpful to remember. The fault isn't with the broken arm, the fault is with the lack of an accessible door.

Um...so we will move on. So critical models are my favorite. And I think that's possibly because I'm kind of a nerd. But I really enjoy critical models because they are more complex than the earlier models,

which allows for a lot of variation in how you can approach things. I'll give a little historical background. Let's see.

Where should I start with this what are critical models? They come out of Marxist analysis. And you'll see people who work academic about this reference people. And not everybody who uses this theory is a Marxist or a academic. And you might hear people say things that seem like they are part of this model, but they might not have heard of this model, this is how they view the world. Like how I spent most of my life I was operating under the medical model until I came across a reference.

The base of critical models or the basis of critical theories is social problems exist in specific con technologies and the purpose of studying the problems is to use what we learn to make people's material experiences better.

I find these models incredibly helpful and understanding myself as a person with disabilities in the workplace and within the larger world. It's also why people with sircht socialite different socialites will have different experiences.

These different critical models examine [audio out] particularly racial identities but also gender and class and sexual orientation. This is important because people with different social identities experience different material and judicial impacts. White high school students with a diagnosed learning disability are more likely to go to college than native or black students with the same disability.

Meanwhile, Native American and black students with a learning disability are more likely to be incarcerated than a white student with the same condition. The disability is the same, but the judicial treatment of people with different ethnic or racial backgrounds is different.

Another reason I really like this particular set of models is that if it were a matter of making society more accommodating, then legislation such as ADA should diminish disability oppression. However, poverty, homelessness and life expectancy have barely moved or in some cases worsened since ADA passed.

The percentage of people with disabilities in the workforce has gone down. And also, a lot of studies don't incorporate different types of disability into their statistics gathering. Any time you see statistics about people with disabilities, it's hard to know how accurate they are depending on how they were constructed and whether people felt safe identifying disabilities.

In terms of the different models presented on the slides, disability critical race studies, I believe that term was coined by Dr. Amana. I never said that out loud before, I only written it. And she's on Twitter. And she's written a lot about disability and race.

Critical disability studies or critical disability theory, I believe that was at least the term was created by Dan and Richard, they have a book about that. I think they are based in an can a Canada. And it influenced people around the English speaking world.

If you are not similar with intersectionality, that was dratted by Dr. Kim interly Crenshaw. And it's an example I mentioned about people with learning disabilities are more likely to either go to college or go to jail, depending on their ethnic background.

The intersectionality looks at society from looking at those -- how those different identities interact. And that was a really horrible explanation of intersectionality. But if you read Dr. Crenshaw's writing, she writes in a way that's clear and easy to understand, even though she's a lawyer. And she has a lot of stuff open access online, I think.

Um, so what I put as a defining term under the critical models because disableperson, disabled as a political identity that's empowering and makes one comfortable taking action in that way. The public health research document you were assigned for this week says that critical disability studies term that they use is differently able. I hate that phrase.

If someone identifies as differently able, I will refer to them with that phrase. But I would never ever use it in any other circumstance. To me, it sounds like a euphemism, not a political identifier. It's like a way of self-coding disability. But there are people people who self-describe. And there are researchers who use it to self-describe. They chosen that for a reason that makes sense to them.

Even though I don't like it at all, I'll use it for people who want to describe themselves that way. Because even though I really don't understand their reasons. They have them and I want to respect that.

So those are the models that you can use and think about in different ways. Within informatics and within disability informatics, I think those models will lead you to approach a lot of work in different ways. I am a cataloger. Which you probably -- I never am quite sure how people respond to my bio where I talk about getting in a fight about public library catalogers about science fiction. And but that's who I am. Ander read books about diagnostics categories for my own entertainment.

When I think about informatics and those models, I think who defines the terms? If someone identifies as differently abled is doing a study, are they going to use the phrase differently abled to conduct that study? Are they going to recognize not everybody likes it and fries to find a different term? Is it someone else who really likes the social model, they are not disabled themselves but they like the person first model. And they want to conduct a study of autistic people using a term people with autism, even

though in some areas that's not considered a great term and you might lose potential participants but you might get more parents.

Who gets to apply the labels? I'm a cataloger, I get to apply labels. Indexers get to apply labels. Doctors diagnosing people get to apply labels. Do disabled people get to apply labels? If so, will they be respected? Also, get who gets to develop hierarchies? Disability is an umbrella concept. Within disability, is there a different hierarchy like visible versus invisible, even though neither term is 100% accurate?

Also, who owns information about disabled people? When I go to the doctor and they draw my blood and they have all my information, does that mean my doctor owns that information?

Do I still own that information? Does my insurance company own that information because they paid for the blood draw? Who can access that information?

I'm not going to go into too much detail about this, but I fairly recently talked with someone who in order to get accommodations paperwork completed, this person was told they would have to sign a HIPAA waiver allowing their employer to access all their medical history. Not just what was immediately appropriate for accommodating a specific disability, but also of their medical history. Personally, I have issues with that. But once again if the employer is paying the insurance company and the insurance company is paying the doctor, who gets to access that then? Do you have to sign away your rights to get accommodations?

How many rights do you have to sign away? Another question, who gets to research disabled people? I identify as disabled. I'm public about it because I have the capacity to be public about it without fearing for my job. If somebody else is writing about disability in a library, I don't know that person. They are not public about it. Does that mean they are not disabled? Maybe it means they are disabled because who else researches us? Who gets to research disabled people? And who gets to be public about having disability?

If there's a disabled person also doing the research. I would say historically it's often not historical people who get to do this research because they are not -- there are too many barriers in the way of preventing access to the resources they need to do the research.

Another question is does research about disabled people benefit them? So if we think about the rehabilitation model that's focused on overcoming or the medical model focused on diagnosis, does having a better diagnose not tick category, is that going to materially improve someone's life? Maybe it does. Maybe it doesn't.

Um...I know that one example I think about when I think about this question is from [inaudible] sorting things out. And the example is of researchers who want grant funding to be able to conduct their research often have to choose areas of study focused on diseases that impact white or European or North American people in affluent areas that have the money to support that research.

And even though research about malaria might save more lives, the money is not there. So that's to me that question goes along with that. And the last issue that I have concerns about is, can disabled people opt out of surveillance? As parts of having diabetes, I'm taking part of a study that allows me access to medical equipment I couldn't otherwise afford. To do that, I upload a lot of information about myself on a weekly basis to get better health care.

I made the decision to do that. I opted in to do that knowing I'm giving away some of my privacy. But not everybody is in a situation where they have the complete ability to opt out. If you can't opt out, then you're not consenting to opting in. if that makes sense.

Makes sense in my head but I'm not sure if I'm explaining that well. But also thinking about -- well, let me check the time quick -- just think about if you are doing research on people, um, make sure they want the research done on them. There's been a lot of push back on this by people from various indigenous communities around the world putting on more boundaries about what kind of research can be done on their commune despite the people in their communities because of historical disrespect from western researchers.

But those are the current issues I wanted to share, to talk about. I have a couple of readings available for people if they want to follow up on this. The respectful disability language thing 1 a two-page PDF just talking about how to use disrespectful terms and use those terms as a conversation between you and people with disabilities. It's not necessarily a strict list.

But it's a conversation. And the library and disabilities bibliography is pretty long. But it has a link and the slides and my notes I talked about today. If you need to go back to it, bookmark it. That's it for my presentation.

I am going to try to figure out...let's see. Stop share. I wanted to make sure there's plenty of time for questions or discussion if people want to engage in that. And Amelia, if you want to take control, that would be great. I'm not sure how 20 give it back to you. Thank you.

>> I took it back. This is our time for questions. Who has questions?

I have a question. You were talking and went through the models and we had -- can you talk a little bit about how some models practically affect the choices we make in providing services maybe? What some examples of those might look like.

>> Let's see. In terms of the moral model, I would think it would be really difficult to think about the moral model in action without thinking about how homeless people are treated in libraries. A lot of -- not all homeless people have disabilities. But it's fairly common for people to become homeless because of their disabilities. So when you have patrons or fellow staff complaining oh, so-and-so stinks or so-and-so is talking to

themselves.

All these things, a lot of that is sort of a lot of that is very judgmental. Very making judgments about the people like about who belongs in the library. Who is allowed to ask questions. Who is allowed to be weird in public.

So the moral model isn't really built to be looked at from an intersectional perspective. But I have a hard time not doing that. So my idea would be to mix and match the different models together in that way. But also another way the moral model could be implemented in a library is, say you're having a work pot luck. And someone says, oh, I'm allergic to peanuts, can we not have peanuts here. How does your library respond to that? Do people agree not to have food with peanuts or do they make a judgment that person doesn't really matter?

That's the moral model. And this is one where I have seen this thing happen. And this example is not coming from nowhere, they are coming from experience. The medical model in action and the library, I would say the medical and a habilitation model would be similar in a sense insisting people have documented disabilities before accommodations are provided, in terms of coworkers and in providing resources to the public. Insisting on having that paperwork filled out before you provide anything that is quote unquote extra.

Those are things that really come from the medical or rehabilitation model.

>> I would guess the idea of accommodations and extra.

>> Yes.

Yes. You are doing a special thing. Or I know this happens a lot where people will say, well, so-and-so is getting special treatment when that quote unquote special treatment is accommodating a disability. That happens in school as well as in the workplace. Sort of any talk about someone being off their meds is sort of a way the medical model is used to stigmatize people. Don't say that to people that just -- that's one I'll say don't do that.

But more positive examples would be if you are looking at the library from the social model and you are going through your library and doing an audit to make sure the entrances are accessible to people with different body sizes, different mobility needs. We have different lighting options for people who need stuff to be bright. And we have lighting options that are less bright for people who suffer from either sensory disabilities or other disabilities where they just need the light to be dimmer in order to function well.

Those would be examples of using the social model to identify barriers in the building and improving the building instead of asking the people to change. That would be probably the best answer I can give to that question.

>> Any other questions?

>> Are certain models more likely to be applied to certain disabilities? Or is there a pattern to that?

>> We have a question from a student asking, are certain models more likely to be applied to certain disabilities or are there patterns you have seen in terms of I guess you could say like diversity as opposed to physical disability, et cetera et cetera.

I'm thinking. >> I'm thinking. I would say, um, -- these patterns I'm thinking of patterns of ableism, which is discrimination against people with certain disabilities. And I would say, no. I know -- hmm -- just because there's stigma against every type of disability, and sometimes it's different kind of stigma, but I don't necessarily know it would be based on these theoretical models. That's a really good question. And I do not have an immediate answer for you. But I'll write it down and do a follow up research. If that's okay.

If I can find a pen that works, I'll write it down.

>> I think that's a good topic for conversation in class too. We have 3 minutes to wrap up. Do we have any last questions? Okay.